471-000-406 Nebraska Medicaid Handicapping Labiolingual Deviation (HLD) Index - (NE-Mod) Orthodontic Diagnostic Score Sheet:

Handicapping Labiolingual Deviation (HLD) Index - NE (Mod):

The submitting dentist shall complete and submit the HLD-Index score sheet when submitting an orthodontic pre-treatment request. The attached score sheet is to be photo copied by the dental office for completion and submission.

If the diagnosed condition does not qualify in 1 - 6 listed on the HLD-Index the dental provider must complete items 7 - 14. The total score on 7 - 14 of the HLD-Index must be 40 or greater to qualify for Medicaid coverage of orthodontic treatment.

Completion instructions are on page 3 of the appendix and on the back of the score sheet.

Nebraska Orthodontic Pre-Treatment Request Form(s):

Orthodontic (interceptive and comprehensive) pre-treatment request must be submitted using the description of the treatment to be completed and the dentist's usual and customary fee. The pretreatment request can be submitted on the Nebraska Interceptive Orthodontic Pre-Treatment Request form, the Comprehensive Orthodontic Pre-Treatment Request form, or on an ADA claim.

Completion instructions for the Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request form are on page 5 of the appendix and on the back of the form.

Completion instructions for the Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request form are on page 7 of the appendix and on the back of the form. .

Nebraska Medicaid
HANDICAPPING LABIOLINGUAL DEVIATION (HLD) INDEX – (NE-Mod)
Orthodontic Diagnostic Score Sheet

Client Name: _____ Client Medicaid Number: _____
Client Birthdate: _____ Client's Chief Complaint: _____

Provider Name: _____ Provider Medicaid Number: _____
Provider Address: _____ Phone Number: _____
State of Dentition: _____ Primary _____ Permanent _____ Mixed

PROCEDURE:

- 1 – 6 - If one of these conditions exist, indicate an "X" and score no further.

1.	Deep impinging overbite.	_____
2.	Crossbite of three or more permanent and/or deciduous posterior teeth or anterior crossbite of one to two teeth.	_____
3.	Congenital birth defect that affects skeletal relationship and/or dentition.	_____
4.	Impacted cuspids with most of the permanent dentition present.	_____
5.	Overjet greater than 9 mm or anterior crossbite	_____
6.	Malocclusion with open bite from canine to canine.	_____

PROCEDURE:

Complete 7 through 14 if case does not qualify in 1 – 6 above. The total score will determine if the case qualifies for orthodontic treatment. Completion instructions are on the back of the form.

- Position the patient's teeth in centric occlusion. Record measurements in the order given and round to the nearest millimeter (mm).
- Enter Score "0" if condition is absent.
- **Note:** When completing #11 & #12, if both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.

	CONDITIONS	**HLD SCORE**
7.	Overjet in mm. (1 – 8 mm)	_____
8.	Overbite in mm. (Anterior crossbite)	_____
9.	Mandibular in protrusion, in mm. (Score # of mm x 5 =) _____ x 5	_____
10.	Open bite, in mm. (Score # of mm x 4 =)	_____
11.	Ectopic eruption: Count each tooth excluding 3rd molars(s) (Score # of teeth x 3 =) List teeth: _____ _____ x 3	_____
12.	Anterior crowding or spacing: Score one point for MAXILLA, and/or one point for MANDIBLE: (Two point maximum)(Score x 5 =) _____ x 5	_____
13.	Labiolingual spread, in mm	_____
14.	Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar). (If present, score 4)	_____
	(7 – 14) TOTAL SCORE	_____

Handicapping Labiolingual Index (HLD) - (NE-Mod)
Scoring Instructions for Severe Malocclusions

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. Absence of any condition must be recorded by entering "0" on 7 - 14. Measurements are rounded to the nearest millimeter.

1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Enter the number of millimeters as the HLD score.

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Anterior crossbite may exist in certain conditions and should be measured and recorded. Enter the number of millimeters as the HLD score. (Vertical measurement.)

9. Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. A anterior crossbite, if present, should be shown under "overbite". The measurement in millimeters is entered on the score-sheet and multiplied by five (5). Enter the multiplied total as the HLD score. (Horizontal measurement.)

10. Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. In cases of pronounced protrusion associated with open bite, measurement of the open bite should be estimated. The measurement is entered on the score-sheet and multiplied by four (4). Enter the multiplied total as the HLD score.

11. Ectopic Eruption: Count each tooth. Teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #12, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.

12. Anterior Crowding or spacing: Arch length insufficiency or excess must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #11, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Two point maximum multiplied by five (5) for a maximum score of 10. Enter the multiplied total as the HLD score.

13. Labiolingual Spread: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is present only the most severe individual millimeter measurement should be entered on the index. Enter the number of millimeters as the HLD score.

14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. If posterior unilateral crossbite is present enter four (4) as the HLD score.

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: **Patient's Medicaid #:**

Birthdate: **Date of Request:**

Provider Name: **Provider Medicaid #:**

Provider Address: (Street, City, State, Zip) **Phone Number:**

Treatment Request:	Maxillary Arch	Mandibular Arch	Fee	Administrative Use Only
Inclined plane (Hawley) appliance, bite plane, with clasps				
Cross-bite appliance, anterior, acrylic				
Cross-bite appliance, posterior, two bands plus attachments				
Adjustments of appliance (# each arch)				
Space maintainer – fixed – unilateral				
Space maintainer – fixed – bilateral				
Description appliance not listed:				

	Number Requested		
Chrome steel wire clasps – each .036 or minimum .030			
Attachment springs for appliance, each			

Diagnostic Narrative:

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form:

Patient Name: Enter the full name (first, middle initial, last name) of the client.

Patient's Medicaid #: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- Appliances: Under the Maxillary Arch and Mandibular Arch column check the type of appliances being requested.
- Adjustments of pedodontic and interceptive appliances: Enter the number of adjustments for the Maxillary arch and Mandibular Arch in the appropriate column.
- Chrome steel wire clasps - enter the number of clasps requested.
- Attachment springs for appliance - enter the number of springs requested.
- Enter the dentist usual and customary fee for each treatment being requested

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Patients Name: Patient's Medicaid #:

Birthdate: Date of Request: Surgical Correction: Yes No Surgical Diagnosis:

Provider Name: Provider Medicaid #:

Provider Address: (Street, City, State, Zip) Phone Number:

Treatment Request	**Maxillary Arch**	**Mandibular Arch**	**Fee**	**Administrative Use Only**
Construct & place fixed appliance, active trt.				
Number of monthly adjustments per arch				
Retainer or retention appliance				
Number of monthly retention visits, per arch				
Other Appliances:				
Rapid palatal expander (RPE)				
Crossbite correcting (fixed appliance)				
Herbst appliance				
Protraction facemask				
Slow expansion appliance				
Headgear				
Space maintainer – fixed - unilateral				
Space Maintainer – fixed – bilateral				
Description orthodontic appliance not listed:				

Diagnostic Narrative:

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form:

Client Name: Enter the full name (first middle initial, last name) of the client.

Client's Medicaid: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the date the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- In the Maxillary Arch and Mandibular Arch column check the column for the treatment or type of appliance being requested for each arch.
- Number of months of arch adjustments – Enter the number of months of monthly adjustments being requested for each arch.
- Number of months of retention appliance treatment – Enter the number of months of retention visits.
- Fee Column: Enter the dentist usual and customary fee for the treatment requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.